TOPIC 4

ALLOCATION, EFFICIENCY, AND EFFECTIVENESS

TOPIC 4. ALLOCATION, EFFICIENCY, AND EFFECTIVENESS

Governments everywhere, pressed for cash, have to rethink priorities to get the best value for their resources as they try to satisfy many competing demands. To stretch their budgets, as a complement to financing reform, governments could devote more of the public health care budget to basic services and less to hospital care. This reallocation could make a big difference in a nation's health, according to many analysts, at the same time improving both efficiency and effectiveness of public health spending.

Basic services include immunizations, prenatal and delivery care, family planning, and curative care for acute respiratory infections, tuberculosis, sexually transmitted diseases (STDs,) and other common childhood and adult ailments. Health centers, health posts, or dispensaries could deliver most of these services. A basic package of health services for a year, covering 98 percent of the usual problems, would cost about $8 per capita in low-income African countries and about $11 per capita in higher income African countries. A full package of health, water, sanitation and institutional support services would cost $13 per capita in low-income countries and $16 in wealthier countries. [19,20]

Central to a good primary care system are supplies of generic essential drugs, community support, quality controls, effective management of personnel, medicines, and supplies, and a network of primary care facilities and first referral hospitals. This would entail financing and resource allocation reforms to achieve:

> increased support for the primary care and district hospital networks

> reduced government and increased private funding for central hospitals and other tertiary care referral hospitals

> broadened financial autonomy for public health facilities.

Major inefficiencies could be addressed by ending medicine and supply shortages, combining multiple outreach trips for special services, curtailing overstaffing at urban and hospital facilities, and improving quality at rural public health facilities to attract more patients. [3,19,22] Poor quality care, especially inadequate supplies of medicines, can lead to inefficient health care services as disgruntled patients seek attention elsewhere, reducing overall cost-effectiveness of services and health worker productivity at the clinic perceived to be deficient.

Individuals, too, could learn to spend more wisely the money they already spend on health care. Well-designed health financing reforms, with appropriate incentives for informed use of the system, could help people save money and improve their health. [11,17,19]

Few African ministries of health (MOHs) have yet made an all-out effort to reallocate resources in ways that improve efficiency and effectiveness. For that reason, hard evidence is slim on the ability of the recommended reforms to achieve their goals. For now, health ministries are weighing the general merits and feasibility of reallocating public resources and using financing reforms to change the way people use health care services. *Topic 4* deals with questions about this course of action.

QUESTION 16: How can governments better use their budgets to improve their people's health?

IN BRIEF: Government has so many competing claims on its limited resources that it has to consider rechanneling its health care spending into services that will do the most good for the most people at the least cost. Management reforms and quality controls could also improve health worker productivity and general health care. These measures that complement financing reforms are particularly difficult and ministries need to build consensus for them.

Specifically, what can governments do? Where should they put their money?

To improve the return in good health from scarce resources, governments could:

> allocate more resources to primary and secondary levels of health care and less to tertiary levels, leaving more hospital costs to be covered by non-tax sources of financing [1,19,21]

> allocate more resources to cost-effective curative and preventive services [20]

> allocate more resources to health education. The education of parents, especially mothers, is the most important determinant of children's health, more important than income and other relevant factors. Good health education is a cost-effective way of fostering healthy practices among the less educated. [7]

> improve efficiency by allocating health personnel according to traffic and by making sure they have enough medications and supplies to do their jobs. In many countries, 60 percent of MOH health personnel, located in the capital, serve barely a quarter of the population. Because of overstaffing, these personnel are underutilized, while health workers in rural areas are underutilized for lack of adequate supplies and medications, and even proper maintenance of equipment. By appropriately reallocating resources, ministries confronted by these and similar inefficiencies could improve health services to the general population without any additional funding. [3,21]

- institute efficient drug procurement and distribution procedures and require use of generic medicines. Waste and inefficiencies in procurement, storage, prescription, and use of therapeutic drugs are so widespread in Africa that patients of public health facilities may be using only $12 worth of drugs for every $100 of MOH budget money spent. [19]

- increase capacities for quality control and related regulation of private providers and suppliers to help reduce delivery of ineffective, over-priced, or unnecessary treatment and drugs. [8,9,11,22]

Why does reallocating spending seem to be so difficult?

Many African health ministries recognize these inefficiencies but find significant steps toward change difficult to take. Many of the most important actions they could take — in areas such as employment, geographic assignment of health workers, making less expensive generic drugs available in public facilities, or favoring primary care over large hospitals — involve touchy political considerations and strong group interests. Health financing reforms such as cost recovery initiatives can help fill the gap in some areas where government has been unable to reallocate needed resources. Other aspects of cost recovery, such as using fee revenues to create different incentives for health workers, may also give ministries some of the additional leverage needed to allocate public resources efficiently.

"Technical" considerations, cost-effectiveness analyses, and efficiency calculations may all help make the difficult choices required in major reallocation decisions. But, for implementation, government administrators need to build consensus among public health personnel, mobilize political resources, and negotiate trade-offs among competing interests.

QUESTION 17: Can financing reforms help households to spend their money for health care more effectively?

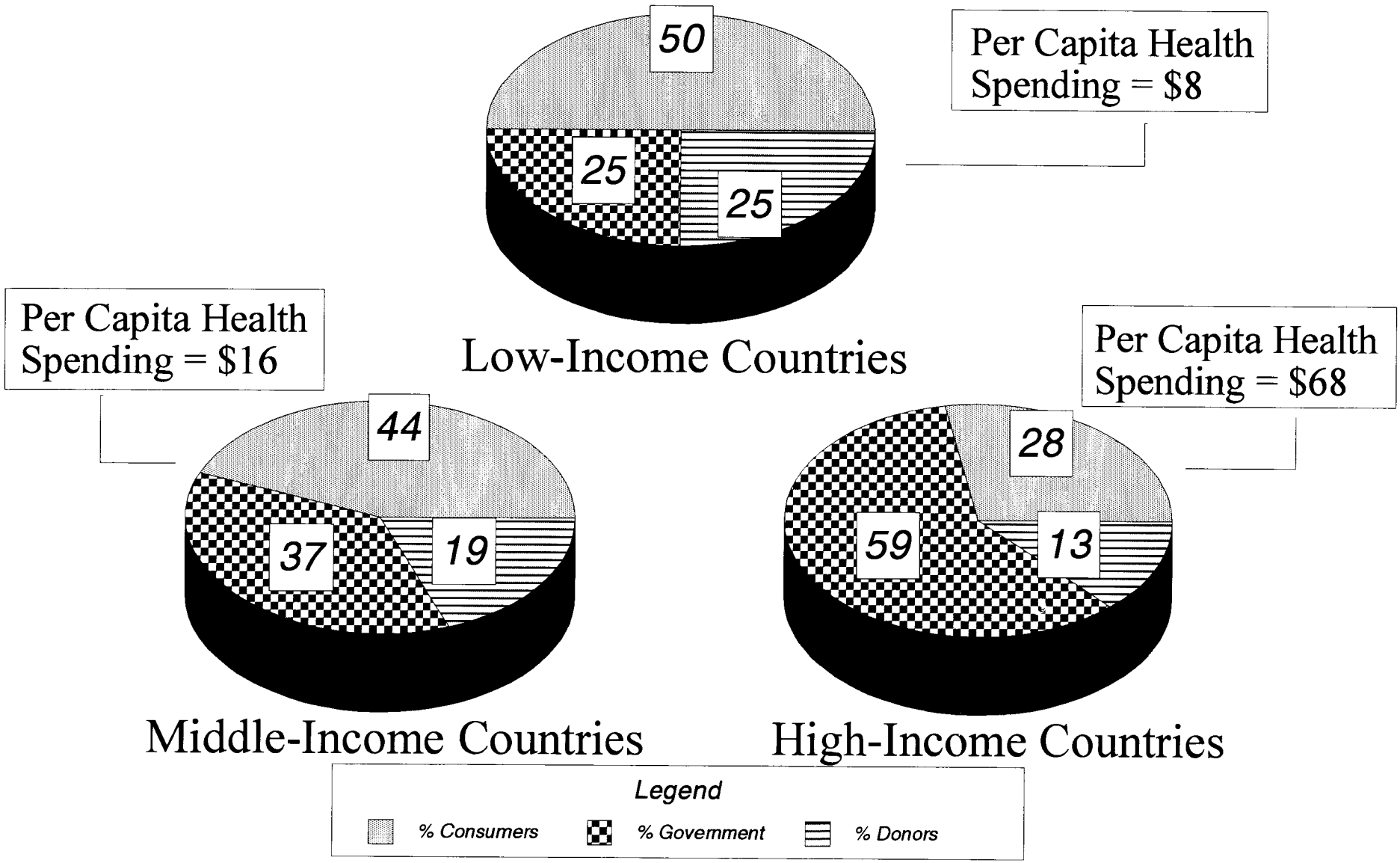
In Brief: Yes. Most African households already spend a good part of their own budgets on health care, especially medicines, but much of this spending is likely to be ineffective. Through user fees and copayments, governments can use prices to influence consumer spending on health care, usually in ways that help people save money and make the health system more efficient at the same time.

How much do African households spend on health care?

Many households spend as much as government does per capita on health care, sometimes more. Among 23 countries in 1990, individuals in the eight lowest income African countries ($225 a year per capita), spent $4 per capita, while government and international donors each spent $2 per capita on health annually. In the four highest income countries (average of $757 per capita), on the other hand, consumer spending on health care amounted to $19 per capita annually, against government's $40. [19]

Private spending thus accounts for an important share of the spending on health care in sub-Saharan Africa (between 28 percent and 50 percent, depending on the country). Government's share is between 25 percent and 60 percent, and external donors fund the rest (between 13 percent and 25 percent). [19] *(Figure 4-1.)*

FIGURE 4-1. PUBLIC VS. PRIVATE SPENDING ON HEALTH CARE IN AFRICA, 1990



Data Source: World Bank 1994.

How do spending patterns differ between low and high-income African countries?

There are strikingly different spending patterns among countries at different income levels in Africa. Government's contribution to health care is smallest in the poorest countries. This means that household spending has the greatest impact on total health spending in the lowest income countries, where 66 percent of the continent's population live. Government represents the largest share of total health spending and has the largest impact in the highest income countries, covering about 5 percent of Africa's population.

In the short run, questions of allocating resources more efficiently rest equally with households and governments in the lowest income countries and largely with government in the middle-income and higher income countries. Low-income countries, spending $8 per capita (including donor funding) on health annually, need to raise absolute levels of spending as well as spend current limited resources as wisely as possible. At $6 per capita, the household and government share of this spending falls short of the World Bank's benchmark estimate of $8 per capita for a package of cost-effective health services, and well below $13 per capita for the full health package that crosses sectors and institutions.

Better-off African countries, spending $68 per capita annually on health, probably need to concentrate strongly on allocating these substantially higher sums effectively. They may need to assess whether their higher spending really buys 17 times better health care than their poorest neighbors receive. Current per capita spending in the wealthier countries also far exceeds the estimated cost ($16 per capita) of a basic package of health, water, sanitation and institutional support services. In these countries, consumer spending alone at $19 per capita could cover the costs of the full basic package.

How do people spend their health care money?

People spend most of their health care money on medicines.

> In the Central African Republic, household spending on drugs alone was equivalent to 47 percent of combined government and donor health expenditure in 1990. [13]

> In Niger, the proportion of drugs bought privately rose from 70 percent in 1980 to 80 percent in 1989. Despite high prices and distance from drug outlets, Nigerien households bought drugs for 43 percent of illnesses. [15]

> In Mali, 90 percent of sales by the pharmaceutical-importing parastatal was to households, accounting for more than 50 percent of estimated expenditures on health services. [18]

People spend money on many other types of health care as well — and from many sources: for modern, traditional, ambulatory and inpatient care, delivered at private, mission, government, non-hospital, and hospital facilities. Payment for preventive services is also more widespread than commonly believed. *(See Question 12)*

Is this money well spent?

About 90 percent of household spending on medications in Africa is usually a waste of money, traceable to inefficient systems for buying, distributing, and prescribing drugs.[19] Government health facilities can typically sell generic drugs for 75 percent less than people pay private pharmacies for brand names. Households could do more for their health by putting money saved by purchasing generic drugs into basic preventive and curative services, whose timely use can reduce their chances of needing expensive hospitalizations. Using basic services at nearby health centers and health posts as the entry point to the health system can also cut the costs of time and travel for outpatient services.

How can financing reforms help households change their health care spending habits?

Health financing reforms based on user fees, public information campaigns, and health education, can motivate households to switch from costly treatments to equally beneficial but less costly treatments. Prices can also prompt people to choose generic drugs over brand names. Cost recovery initiatives that make low-cost, essential medicines available closer to home can save consumers large sums.

One of the most important functions of cost recovery reforms is to establish user fees and copayments that signal the most appropriate level of care in choices among primary, secondary, and tertiary health facilities, and that encourage use of cost-effective services for improving health status (e.g., family planning, immunizations, prenatal care, and safe delivery services.) [1,5,17]

> In Senegal and Ghana when fees existed at the primary care level but not at hospitals, patients crowded into hospital outpatient units and left rural health facilities empty. In 1991, 11 government hospitals in Ghana saw twice as many outpatients as the entire rest of the government health network. [17]

> Malawi, Zimbabwe, Niger and the Central African Republic have all structured their fee systems with the highest user charges for outpatient care at central hospitals, medium charges at district hospitals, and lowest at primary care facilities. [6,10,12,17]

> In Kenya, after hospitals introduced fees, use of their outpatient services declined by 37 percent, while use of government dispensaries, which remained free-of-charge, increased about 10 percent. [1]

> In Sudan, after hospitals introduced user fees, former outpatients also sought less costly treatment lower in the system, and overcrowding eased at hospitals. [2]

> In Kasongo District in Zaire, user fees cut back use of the district hospital as a first point of service by 90 percent and quadrupled attendance at district health centers. [17]

> In Zambia, however, despite coordinated fees, hospitals are still flooded with outpatients, and health centers remain underused. [1]

Thus, though promising, coordinated pricing between various levels of the health system does not guarantee efficient use of health services. Buttressing measures such as quality control and improved referral procedures are usually needed.

Both households, with so many out-of-pocket expenditures for health care, and governments, with so many pressures on resources, have strong self-interest in getting the most for their money. The impact of user fees and copayments on health care use suggests that governments can play a major role in that quest by providing incentives through appropriate financing reforms and by making cost-effective services and low-cost generic medicines more widely available.

QUESTION 18: Can hospital autonomy help governments reduce hospitals' share of the public health budget in favor of primary health care?

In Brief: "Hospital autonomy" is one of the longer run goals of financing reforms that seek to increase cost recovery in hospitals. Several African ministries of health have begun to phase in partial financial and managerial autonomy for hospitals. Experience elsewhere in the world suggests that insurance is necessary for full autonomy to be a viable option. Autonomy largely based on health insurance may free the government from funding some public hospitals but brings with it possible trade-offs in efficiency and equity for the health system as a whole.

Why consider hospital autonomy?

Hospitals absorb between 40 percent and 80 percent of the public health budgets in sub-Saharan Africa. The predominance of hospitals in the funding picture reflects their heavy allocation of health personnel— and their salaries. Yet the same hospitals are underfunded for non-salary operating costs (e.g., medicines, X-ray and laboratory supplies, consumable equipment, laundry and food services). Public hospitals in most sub-Saharan African countries have long used inpatient fee systems, but often these fees are outdated, collected erratically, and not returned to hospital use. In any case, fees do not cover the shortfall between needed and available funds for minimum standards of care.

In addition to introducing user fees and cost recovery, many experts have suggested that hospitals should be given formal, legal status for financial and managerial autonomy, especially the large central referral hospitals. Under these proposals, hospitals could be fully autonomous or partially autonomous parastatals or could selectively privatize certain services (e.g., meals, laundry, laboratory testing). Hospitals receiving this status would be separated from the subsidized government health system in the hope of reducing government subsidies to hospitals. The public resources thus freed would be channeled into subsidies for preventive health care and services for the indigent.

Full management autonomy is thought to increase incentives for better use of resources by hospital staff. If freed from central MOH requirements, hospital administrators would have flexibility for hiring and firing employees, providing performance incentives, adjusting fee levels, and making efficient and timely purchases of medicines, other supplies, and equipment. Community or other public boards, perhaps with some MOH and local government members, would help to hold the hospital accountable.[1]

Have any African countries given large hospitals financial and managerial autonomy?

A few countries have begun to give government hospitals some legal and financial autonomy, but it is too soon to assess the results.

> Kenya, the Gambia, Niger, Côte d'Ivoire, and the Central African Republic have given partial financial and managerial autonomy to large central hospitals and district hospitals.[1,4,10,14,17]

> Burundi tested a phasing plan for granting full hospital autonomy by providing one 120-bed hospital a lump sum to cover the hospital's operating costs and reducing that grant by 20 percent each year thereafter. Given the success of the experiment, the MOH plans to use the same approach for its 600-bed central hospital. [19]

> Tanzania, Mozambique, and Kenya are privatizing selected services, beds, or wings in central government hospitals. [19]

The short-run goal of planned hospital autonomy in most African countries coincides with that of cost recovery in general: to cover non-salary operating costs and to improve quality with new revenue from user fees (and insurance reimbursement, where possible), while government continues to pay the salaries of hospital medical personnel. In the longer run, as hospital financing prospects improve with better cost recovery and possibly health insurance, these efforts may lead to full financial autonomy. *(See Question 7)*

What does worldwide experience say?

Financing reforms for public hospitals are too new in Africa to know if enough funds could be freed up to be reallocated to primary care and make a difference. Efforts in other parts of the world that have attempted full financial autonomy for hospitals through health insurance (e.g. Brazil, China, Korea, Thailand) provide some useful lessons. This other experience suggests that, with health insurance, hospital costs might be fully covered and relieve governments of funding responsibilities.

These efforts also raise several questions about whether this method can improve efficiency and equity for the health system as a whole. Health insurance can lead to skyrocketing costs and skew resources more toward tertiary level, high-technology care than before. It can create overuse by covered patients and inequities between the insured and non-insured, who are often less advantaged in the first place.[1,16] Few countries with widespread insurance have mastered these problems on a national level, even though a wide variety of utilization, quality, and reimbursement controls have been tried.

TOPIC 4 REFERENCES

1. Barnum, H., and J. Kutzin. 1993. *Public Hospitals in Developing Countries: Resource Use, Cost, Financing*. The World Bank. Baltimore and London: Johns Hopkins University Press.

2. Bekele, A., and M. A. Lewis. 1986. "Financing Health Care in the Sudan: Some Recent Experiments in the Central Region." *International Journal of Health Planning and Management* 1:11-127.

3. Bitran, R., S. Brewster, B. Ba. 1994. "Costs Financing, and Efficiency of Health Providers in Senegal. A Comparative Analysis of Public and Private Providers." Major Applied Research Paper No. 11 (Phase III). HFS Project, Abt Associates Inc., Bethesda, MD.

4. Collins, D., and I. Hussein. 1993. "Financial Sustainability of Health Programs in Kenya: The Role of Cost Sharing." Paper prepared for the 121st Annual Meeting of the American Public Health Association. Management Sciences for Health (MSH), Boston, MA.

5. Griffin, C. 1988. "User Charges for Health Care in Principle and Practice." Seminar Paper 37. Economic Development Institute, The World Bank, Washington, DC.

6. Hecht, R., C. Overholt, and H. Holmbert. 1993. "Improving the Implementation of Cost Recovery for Health: Lessons from Zimbabwe." *Health Policy* 25.

7. Herz, B., K. Subbarao, M. Habib, and L. Raney. 1991. "Letting Girls Learn: Promising Approaches in Primary and Secondary Education." The World Bank Discussion Paper 133. The World Bank, Washington, DC.

8. Knowles, J., A. Yazbeck, and S. Brewster. 1995. "The Private Sector Delivery of Health Care: Senegal." Major Applied Research Paper No.16 (Phase III). HFS Project, Abt Associates Inc., Bethesda, MD.

9. Leighton, C. 1995. "Overview: Improving Quality and Access to Health Services Through Health Financing Reform in Sub-Saharan Africa." *Health Policy and Planning* 10(3):213-21.

10. Leighton, C. 1994. "A Proposed Fee Structure and Prices for A National Program of Cost Recovery for Health Services in the Central African Republic." Technical Note No. 39. HFS Project, Abt Associates Inc., Bethesda, MD.

11. Leighton, C. 1992. "Planning Activities for Hospital Reform in Niger." Trip Report. Abt Associates Inc., Bethesda, MD.

12. Leighton, C., with R. Foster, J. Ouma, J. Wang'ombe, O. Ekanem, W. Brieger, M. Ettling, S. Zaman. 1993. "Economic Impacts of Malaria in Kenya and Nigeria." Major Applied Research Paper No.6. HFS Project, Abt Associates Inc., Bethesda, MD.

13. Makinen, M., and K. McInnes. 1991. "Evidence on the Effectiveness of User Charges: Experiences from Africa." Abt Associates Inc., Bethesda, MD.

14. McInnes, K. 1991. "Hospital Reform in Niger: Work Performed by DEP and Tulane/Abt under the Niger Health Sector Grant, 1988-1991." Abt Associates Inc., Bethesda, MD.

15. Ministère de la Santé Publique et des Affaires Sociales, Niger, Cellule de Planificaton. 1987. "Enquête National sur l'Utilisation des Services de Santé." Projet Tulane, Niamey.

16. Nittayaramphong, S., and V. Tangcharoensathien. 1994. "Thailand: Private Health Care Out of Control?" *Health Policy and Planning*. 9(1).

17. Shaw, R. Paul and C. Griffin. 1995. *Financing Health Care in Sub-Saharan Africa Through User Fees and Insurance*. Directions in Development, The World Bank. Washington, DC.

18. Unger, J.P., A. Mbaye, and M. Diao. 1990. "From Bamako to Kolda: A Case Study of Medicines and the Financing of District Health Services." *Health Policy and Planning* 5(4): 367-377.

19. The World Bank. 1994. *Better Health in Africa: Experience and Lessons Learned*. Washington, DC.

20. The World Bank. 1993. *World Development Report 1993: Investing In Health*. Washington, DC.

21. The World Bank. 1987. *Financing Health Services in Developing Countries: An Agenda for Reform*. The World Bank, Washington, DC.

22. Wouters, A. 1994. "Quality of Health Care and Cost Recovery in Africa: Evidence from Niger and Senegal." Major Applied Research Paper No.13. HFS Project, Abt Associates Inc., Bethesda, MD.